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July 1, 2019

Karen Tritz
Director
Quality, Safety & Oversight Group
Department of Health and Human Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

RE: QSO-19-13-Hospital – DRAFT ONLY – Guidance for Hospital Co-location with Other Hospitals or Healthcare Facilities

Dear Director Tritz,

The National Rural Health Association (NRHA) is pleased to offer comments on the CMS **QSO-19-13-Hospital Guidance for Hospital Co-location with Other Hospitals or Healthcare Facilities**. We appreciate your continued commitment to the needs of the 62 million Americans residing in rural areas and look forward to our continued collaboration to improve health care access and quality throughout rural America.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses and patients. We work to improve rural America's health needs through government advocacy, communications, education and research.

NRHA appreciates this draft guidance, as it signals a positive step for co-location at non-CAH rural hospitals. We do have concerns about the continued delay of guidance for CAHs, especially due to the importance of visiting specialists. Rural communities with CAHs rely upon visiting specialists, and it is imperative that the guidance reflect these rural challenges. Also, NRHA urges CMS to develop more flexible Medicare Conditions of Participation that take into account rural hospitals' specific circumstances.

Burden on Rural Providers

Burdensome regulation requirements (such as exclusive entrance, waiting and registration areas, permanent walls, and a distinct suite designation) should not apply to small rural facilities since they are often prohibitively expensive or not physically possible. Current regulation enforcement has seen rural communities lose access to specialists including a pediatric gastroenterologist, gynecological oncologist, and pediatric cardiologist.

By enforcing these requirements, CMS is exacerbating access issues in rural communities. In rural America, access to primary care is limited and access to specialty care is even more scarce, and rural Americans often travel several hours to seek care. Visiting specialists are crucial to sustaining access to cardiologist, oncologists, and pediatric surgeons in rural communities.

Allowing visiting specialists to utilize provider-based clinics is a cost-effective way to sustain necessary specialty care access.

Rural and frontier hospitals provide medical care in clinics that have limited staff, operational space and financial resources. Visiting specialty physicians have limited ability to provide needed care at outreach clinics due to the enforcement of restrictive CMS policies. For example, only employed physicians or billing contracted physicians can provide services in provider-based clinic settings and CMS also prohibits co-location in the hospital settings. Furthermore, CMS references the Conditions of Participation in their citations, which impedes other specialists who do not bill Medicare, such as pediatric specialists, from reaching these rural populations.

Shared Space

The draft guidance suggests that the separation of clinical space is necessary “due to infection control, patient management, confidentiality, and other quality and safety concerns.” These concerns could be easily addressed for rural PPS and CAH hospitals by simply not allowing for the sharing of clinical space simultaneously. To solve this problem, during the time that the visiting specialists are on site that space would be solely used by the specialist and not be allowed to be used by the CAH or PPS hospital. When the visiting specialists are not on site, the CAH/PPS hospital could then revert that space back to the original usage. Our belief is that it would be appropriate to alleviate any patient confusion by requiring facilities to notify patients when space is being shared with physicians and by adding temporary signage to that effect.

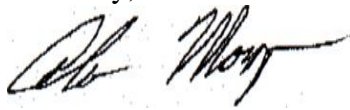
While this goes beyond the scope of the guidance, we would note that alternatives to sharing space are unworkable because they create unnecessary complexities. These complexities such as calculation of fair market value for facilities at a time when many communities have no comparable locations in addition to complicated billing scenarios that, in some cases, would end up costing Medicare more. In the past, some CMS regional offices have taken an expansive view of existing law, regulation, and commentary in determining that shared space within a provider-based facility is prohibited. There actually is nothing in the law or the regulations that addresses shared space.

Rural communities are often the epicenter of innovation. If CMS denies provider-based status to facilities based on the fact that they share space with visiting specialists or subspecialists, these

innovative ways of delivering care will falter and patients in underserved communities will suffer. There have been examples, such as Montana, of integrative and innovative solutions to taking care of its population in rural areas with the limited resources available and these systems has worked well. CMS has stated their desire for innovation in health care, and if not changed, that innovation will be stymied in rural America.

We very much look forward to continuing our work together to ensure our mutual goal of improving quality of and access to necessary care in rural America. If you have any questions, please have your staff contact Max Isaacoff at misaacoff@nrharural.org or 202-639-0550 to discuss our concerns. We look forward to hearing from you.

Sincerely,

A handwritten signature in black ink, appearing to read "Alan Morgan". The signature is fluid and cursive, with a long horizontal stroke at the end.

Alan Morgan
Chief Executive Officer
National Rural Health Association